State of Vermont
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston VT 05495-2807
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Agency of Human Services

Providers,

Please review the following policy summary and attached materials that describe the specific changes being proposed as part of the DVHA's annual professional services fee schedule. The DVHA invites comments and feedback regarding the all aspects of the proposed changes.

Any comments should be submitted to the DVHA Reimbursement Unit by the due date specified. Your comments must be received by the due date to be considered before the final policy is released.

Send Comments to: DVHA Reimbursement Unit
312 Hurricane Lane, Suite 102
Williston, VT 05495
AHS.DVHAReimbursement@state.vt.us

Thank you for your consideration,

Kara Suter, M.S., Director of Payment Reform and Reimbursement
Christine Blackburn, Interim DVHA Rate Setting Manager

Comments Due: 12/15/2014

Proposed Effective Date: 1/1/2015

Policy Subject

Professional rates valued under the Resource Based Relative Value System (RBRVS)

Purpose

Yearly RBRVS and professional rate updates effective for CY2015

Policy Summary

The DVHA is proposing to update the RBRVS rates and conversion factor as currently done each year, as well as some additional updates which will become effective in CY2015. These items include:

- Conversion Factor (CF) update
- Relative Value Unit (RVU) updates
- Geographic Practice Cost Index (GPCI) updates
- Complex Care Management
- Conclusion of the Enhanced Primary Care Program (EPCP)

A financial impact table is also included in the summary of proposed policies. The total payments under this system remained consistent between 2014 and 2015 and there was little change due to updates in utilization data, RVUs and GPCIs. Since the Medicare program ended the transition to new RVUs in 2014, it was expected that 2015 changes would be much more stable than in the previous four year transition period.

There is one exception. As of 1/1/2015, the federal government will no longer be funding the Enhanced Primary Care Program (EPCP). Therefore, the Medicare conversion factor (CF) is no longer applicable to the select set of E&M and vaccine administration covered for those qualifying providers. Negative impacts shown in the impact analysis therefore, relate specifically to the change from the Medicare CF to the proposed 2015 Medicaid CF for these select services and providers.

Overview of Each Update:

1. Conversion Factor Update

Under the RBRVS methodology, the Conversion Factor converts the RVU's into a rate. The conversion factor will remain the same in CY2015, $28.71.

2. RVU Updates

Each year, Medicare assigns each CPT code valued under the RBRVS methodology a Relative Value Unit (RVU). An RVU captures the three following components of patient care:

- Physician Work RVU
  - The relative level of time, skill, training, and intensity to provide a given service.
- Practice Expense RVU
  - Addresses the costs of maintaining a practice including clinical labor, supplies and equipment as well as indirect expenses such as rent and non-physician staff costs.
- Malpractice RVU
  - Represent payment for the professional liability expense, and generally the smallest component of the RVU values.

For 2015, the DVHA will update all RVUs with those finalized by Medicare on October 31, 2014.[1]

3. Geographic Practice Cost Index (GPCI) Updates

Medicare also updates the Geographic Practice Cost Index (GPCI) for each RVU annually. For 2015, the DVHA will update GPCI's for Vermont finalized by Medicare on October 31, 2014.[1] The table below summarizes the changes in GPCI in 2015 compared to 2014.

[1] (FederalRegister.gov Medicare Program; MPFS 2015 Final Rule https://www.federalregister.gov/articles/2014/11/13/2014-26183/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory)

	CY2014	CY2015
GPCI for Work	1.000	1.000
GPCI for Practice Expense	1.006	1.004
GPCI for Malpractice	0.618	0.618

4. Complex Care Management

On October 31, 2014, Medicare finalized the policy related to a new chronic care management (CCM) code (CPT 99490). Chronic care management services include at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- Comprehensive care plan established, implemented, revised, or monitored.

Medicare also finalized its policy that providers already receiving payment for CCM services through alternative payment models would not be eligible to bill for fee-for-service CCM services.

> *The Multi- payer Advanced Primary Care Practice (MAPCP) Demonstration and the Comprehensive Primary Care (CPC) Initiative both include payments for care management services that closely overlap with the scope of service for the new chronic care management services code. In these two initiatives, primary care practices are receiving per beneficiary per month payments for care management services furnished to Medicare fee-for-service beneficiaries attributed to their practices. We proposed that practitioners participating in one of these two models may not bill Medicare for CCM services furnished to any beneficiary attributed to the practice for purposes of participating in one of these initiatives, as we believe the payment for CCM services would be a duplicative payment for substantially the same services for which payment is made through the per beneficiary per month payment.*[1]

Medicaid currently makes payments to primary care providers under the Multi-payer Advanced Primary Care Practice (MAPCP) demonstration through its contributions based on NCQA accreditation and to support Community Health Teams (CHTs). In addition to participation in the MAPCP, primary care providers also receive a separate primary care case management (PCCM) payment to support care management activities. Therefore, the DVHA proposes not to allow for separate reimbursement through the fee-for-service professional fee schedule.

One current limitation in being able to monitor and evaluate the effectiveness of its support of care management services under the MAPCP is a lack of data. The lack of data also limits the DVHA's ability to demonstrate non-duplication of payments. Therefore, the DVHA is proposing voluntary reporting of CPT 99490 effective 1/1/2015 and mandatory as of 7/1/2015. The DVHA is seeking specific input on the proposal to make reporting mandatory as of 7/1/2015.

5. Conclusion of Enhanced Primary Care Payments (EPCP)

To increase support for physicians providing primary care for Medicaid beneficiaries, and to improve access to primary care as Medicaid coverage expands, the Affordable Care Act (ACA) had increased Medicaid payment rates for many primary care services to Medicare fee levels in CY2013 and CY2014. The federal government funded 100% of this primary care fee increase.

As of 1/1/2015, the federal government will no longer be funding the Enhanced Primary Care Program (EPCP). Therefore, the Medicare conversion factor (CF) is no longer applicable to the select set of E&M and vaccine administration covered for those qualifying providers. Negative impacts shown in the impact analysis therefore, relate specifically to the change from the Medicare CF to the proposed 2015 Medicaid CF for these select services and providers.

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Provider Impact

		Model 1	Model 2	Model 3	Model 4
Baseline Pricing and Policy Changes		Baseline 2014 Pricing	EPCP Payments Out	2015 RVUs	2015 RVUs and GPCIs
Utilization Used in Model		CY 2013	CY 2013	CY 2013	CY 2013
Medicare RVU File Used	CY 2013	CY 2014	CY 2014	CY 2015	CY 2015
Conversion Factor- Standard	$27.1624 Jan-Oct; $27.8624 Nov-Dec	$28.7100	$28.7100	$28.7100	$28.7100
Conversion Factor- EPCP	$36.0666	$36.0666	$27.8624	$27.8624	$27.8624
GPCI for Work	0.977	1.000	1.000	1.000	1.000
GPCI for Practice Expense	1.008	1.006	1.006	1.006	1.004
GPCI for Malpractice	0.554	0.618	0.618	0.618	0.618

Procedure Code	Units	Paid Amount (2013)	Modeled Payments	Modeled Payments	Modeled Payments	Modeled Payments
All Codes	**1,859,604**	**$99,795,344**	**$105,291,209**	**$99,047,496**	**$98,993,838**	**$98,923,475**
Change from Baseline (Model 0)				**($6,243,713)**	**($6,297,371)**	**($6,367,734)**

Provider Type or Specialty	Units	Paid Amount (2013)	Modeled Payments	Modeled Payments	Modeled Payments	Modeled Payments
All Provider Types/Specialties	**1,859,598**	**99,794,974**	**105,290,885**	**99,047,169**	**98,993,510**	**98,923,149**
All Codes Primary Care Physicians	498,701	$31,650,719	$31,301,227	$26,094,965	$26,183,971	$26,160,630
All Codes Primary Care Nurses	67,089	$4,022,576	$4,058,486	$3,676,953	$3,686,726	$3,683,189
All Codes OB/GYN Services	55,594	$6,086,733	$6,480,274	$6,443,417	$6,395,956	$6,390,798
All Codes Specialists	275,042	$20,928,922	$22,171,016	$21,882,236	$22,016,228	$21,999,061
All Codes Psychiatrists	105,965	$5,092,102	$5,706,512	$5,706,512	$5,683,063	$5,680,115
All Codes MS Psychologist	365,251	$14,228,128	$16,031,681	$16,031,681	$15,862,937	$15,858,661
All Codes PhD Psychologist	56,312	$2,720,377	$3,051,256	$3,051,256	$3,020,716	$3,019,823
All Codes Radiologists	122,826	$2,980,287	$3,142,790	$3,142,790	$3,129,284	$3,127,510
All Codes Podiatrists	5,649	$393,443	$416,499	$416,499	$417,390	$416,951
All Codes Optometrist/Optician	38,814	$1,905,225	$2,038,776	$2,038,776	$2,024,304	$2,022,141
All Codes Therapist	129,663	$3,313,416	$3,449,133	$3,449,133	$3,454,956	$3,451,517
All Codes Chiropractor	24,569	$712,008	$836,600	$836,600	$833,150	$832,546
All Codes All Other	114,123	$5,761,038	$6,606,635	$6,276,351	$6,284,829	$6,280,207